THE enable PROJECT

ENABLING CHANGE FOR WOMEN'S REPRODUCTIVE HEALTH

LINKAGES BETWEEN PARTICIPATION IN DEMOCRATIC ACTIVITIES AND REPRODUCTIVE HEALTH BEHAVIORS

A Case Study of Plateau State, Nigeria

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Linkages between Women's Participation in Democratic Activities and Reproductive Health Behaviors: A Case Study of Plateau State, Nigeria

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBD	Community-Based Distributor
CBA	Community-Based Advocate
CEDPA	The Centre for Development and Population Activities
COCIN	Church of Christ in Nigeria
DG	Democracy and Governance
EA	Enumeration Area
ENABLE	Enabling Change for Women's Reproductive Health (CEDPA project)
HIV	Human Immunodeficiency Virus
LCC	Local Church Council
LGA	Local Government Area
NGO	Non-Governmental Organization
NISER	Nigerian Institute of Social and Economic Research
NPC	National Population Commission
RH	Reproductive Health
SES	Socio-Economic Status
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNAIDS	The Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

Executive Summary

This case study of Plateau State, Nigeria, examines linkages between women's participation in democracy and governance (DG) activities, women's empowerment, and reproductive health (RH) behaviors. It evaluates the RH and DG activities that CEDPA implemented with its local partner, the Church of Christ in Nigeria (COCIN), under the United States Agency for International Development (USAID)-funded Enabling Change for Women's Reproductive Health (ENABLE) project.

One of ENABLE's key objectives is to improve women's reproductive health by promoting an enabling environment that strengthens women's informed and autonomous decision making. Working in Ondo and Plateau states in Nigeria with local partners such as COCIN, ENABLE project interventions were designed to expand access to an integrated package of RH services, enhance the community workers' role in empowering women and improving RH, and increase community participation in mobilizing resources and building coalitions for RH and reproductive rights. Linkages were also made between RH activities and non-health activities, including DG. The underlying belief was that, by expanding women's participation in politics and the democratic process, their power and control in other areas – including RH – would be improved.

The evaluation was based on a conceptual framework that recognizes that women's empowerment is influenced by the social, cultural, economic, political, and legal contexts in which they live.

The evaluation team used a four-cell quasi-experimental design to assess the impact of DG and RH interventions. Four of Plateau State's 17 local government areas (LGAs) were chosen: Bokkos, Langtang-South, Pankshin, and Quan'pan. In three of the four LGAs, COCIN implemented its intervention programs; it implemented RH activities in Langtang-South LGA, DG activities in Pankshin LGA, both RH and DG activities in Bokkos LGA, and no activities in Quan'pan, which served as the study's control LGA. The women were selected from each LGA using a representative sampling framework of ever-married/cohabiting women aged 15 to 49. Field teams interviewed a total of 2,000 women in the four LGAs, exactly 500 per LGA.

The data on the respondents' socio-economic and demographic characteristics show that over 90 percent of the ever-married sample is currently married, and the majority (82%) are Christians. The profile of the control area showed the respondents as somewhat less educated (51% uneducated vs. 40% overall), of lower socio-economic status (SES), and a higher percentage Muslim (37%), than the other three LGA intervention areas. Coverage of community-based distributor (CBD) visits to the respondents ranged from one-quarter in the RH/DG combined area and 20 percent in the RH-only intervention area, to only 11 percent in the DG-only area and five percent in the control area.

The bivariate findings show that women in the RH/DG combined communities scored higher on all of the empowerment and RH indicators. For the empowerment indicators, less than 30 percent of the women overall consider making decisions on health care, household item purchases, and visits to relatives a matter of joint input by husband and wife, and 14 percent a prerogative of the women alone. The exception is in the RH/DG combined communities, where 22 percent consider

it to be their prerogative. The RH/DG combined communities also scored higher on the sexual empowerment index (84% vs. 61% in the control area) and on the mobility index (81% vs. 58% in the control and DG only areas).

Concerning family planning, only 8.6 percent of the non-pregnant women in the total sample are currently using modern methods. Contraceptive use is higher (12%) in the RH/DG combined area and lower (6.8%) in the control area. Many more women say they intend to adopt contraceptives in the future, with the highest proportion in the RH/DG combined communities (53% vs. 40% in the control). Concerning participation in DG activities, some 27 percent have participated in them, ranging from 30 to 34 percent in the RH/DG combined and RH-only areas, to only 16 percent in the control area.

Current use of modern family planning methods is twice as high among more educated women (13.0% for those with secondary school and above vs. 6.7% for the less educated). After controlling for educational level, the personal variables that are significantly related to contraceptive use include urban residence, older age, non-Catholic or Islam religion, exposure to radio, SES, and mobility, as well as the RH and DG program exposure and study area variables. For example, nearly one-quarter of the educated, urban women were currently using contraception vs. only 5.5 percent of the less educated rural women. Moreover, 21 percent of the educated women visited by CBDs were currently using contraception vs. only 5.5 percent of the less educated women who were not visited. The logistic regression on current contraceptive use shows that older age and visits by CBDs had the most significant explanatory power, followed by SES, education, mobility, and sexual empowerment; however, religion, residence, and DG exposure had no significant link.

Those women visited by CBDs and those whose husbands have higher education levels are more likely to say they intend to use family planning. The logistic regression indicates that higher age, education, religion, DG exposure, CBD visits, and mobility have the highest significance.

Finally, logistics regressions were run on exposure to CBD and DG activities. Overall, factors such as older age, religion, radio exposure, intervention area, mobility, and sexual empowerment remain significant determinants of contact with CBDs. Concerning the determinants of DG activities, religion (e.g., COCIN and other Christians), urban residence, radio exposure, husband's education, and mobility are the most significant.

We can conclude that both individual women's and program exposure variables are important for reproductive health behavior. This behavior is a function of both socio-cultural and women's empowerment variables. This study lends support to the idea that participation in democratic activities, such as registration to vote and questioning of political candidates, does lead to a greater sense of independent thinking.

The study also confirms that the dual program exposure to human and reproductive health rights is likely to enhance reproductive health behavior above the level achieved by direct family planning interventions alone.

There are important implications for future programs. The teaching of civic responsibilities and duties within an enabling women's empowerment environment of advocacy and social mobilization should be incorporated into RH programs. However, before basing programmatic decisions on these conclusions, this study should be replicated in other settings with more stable environments.

Linkages between Women's Participation in Democratic Activities and Reproductive Health Behaviors: A Case Study of Plateau State, Nigeria

I. Introduction

In recent years, reproductive health programs have increasingly recognized that women lead multi-dimensional lives. Women do not function in isolation but in a complex environment with their spouses, families, and communities. This environment conditions the extent to which they are able to gain knowledge and make decisions about reproduction and health and use health services. Empowering individual women and creating an environment where they can control their lives and surroundings are seen as crucial to improving reproductive health (RH) outcomes. Moreover, interventions that empower women in the diverse aspects of their daily lives can build on each other to bring about improvements not only in RH, but also in other areas such as poverty reduction and effective governance (World Bank, 2001).

One of the two primary objectives of the Enabling Change for Women's Reproductive Health (ENABLE) project in Nigeria, funded by the United States Agency for International Development (USAID), is to improve women's reproductive health by promoting an enabling environment that strengthens women's informed and autonomous decision making. Working in several states in Nigeria with local partner non-governmental organizations (NGOs), ENABLE project interventions were designed to expand access to an integrated package of RH services, enhance the community workers' role in empowering women and improving RH, and increase community participation in mobilizing resources and building coalitions for RH and reproductive rights. Linkages were also made between RH activities and non-health activities, including democracy and governance (DG). The underlying belief was that, by expanding women's participation in politics and the democratic process, their power and control in other areas – including RH – would be improved.

It is now widely acknowledged that access to and control of resources in a society are power issues. In Nigeria, as in many African nations, women's access to land and other productive resources is constrained as a result of cultural, traditional, political, and sociological factors. Despite the fact that women are about half of Nigeria's population and make significant contributions to household security and national development, women remain much more vulnerable than men and are discriminated against either by commission or omission. Consequently, empowering individual women and creating an enabling environment where they are in a position to control their lives and surroundings are critical to improving RH outcomes on one hand, and DG and poverty alleviation on the other (Blanc, 2002; World Bank, 2001).

Rising HIV/AIDS Prevalence among Women in Nigeria

UNAIDS (2000) estimates that adolescent females are generally at higher risk for HIV/AIDS than are their male counterparts. HIV prevalence rates among the 15 to 25 year cohort range between 4.0 to 5.89 percent for females and from 1.98 to 3.35 percent for males. In Nigeria, the HIV prevalence rate has maintained an upward trend from 1.8 percent in 1991 to 5.8 percent in 2001 among pregnant women (Federal Ministry of Health, 2001).

In Plateau State, the HIV prevalence rate rose from 6.2 percent in 1991 to 8.2 percent in 1993, before it dropped to 6.1 percent in 1999. However, by 2001, it had risen even higher to 8.5 percent (Federal Ministry of Health, 2001; Ajakaiye, *et al*, 2002).

An enabling environment for women's empowerment includes expanded rights and opportunities encompassing, but not limited to, full political participation, access to basic services especially health care and education, economic self-reliance, property ownership and inheritance rights, and the elimination of gender-based discrimination and exploitation (Dixon-Mueller and Germain, 2001; Blanc, 2002).

In this regard, the need for greater women's empowerment and equal rights have been cited in a number of global policies, including: the Convention on the Elimination of All Forms of Discrimination against Women; Agenda 21 adopted at the Rio Summit 1992; the Beijing Declaration and Platform for Action, 1995; the Programme of Action of the International Conference on Population and Development, 1994; and the Commission on Human Rights Resolution 2000/13. These include women's equal ownership of, access to, and control over land, equal rights to own property, and adequate housing. The ENABLE project supports and promotes the empowerment of and equal rights for Nigerian women.

Background

In December 2002 and January 2003, CEDPA conducted a case study in Plateau State to evaluate the effectiveness of the ENABLE project's RH and DG interventions with the Church of Christ in Nigeria (COCIN). COCIN's work with ENABLE began in 1998 with DG activities in Plateau State. At the request of COCIN's Women's Fellowship, ENABLE added integrated reproductive health services in 1999, extending RH to seven LGAs in Plateau State. COCIN is a faith-based organization that combines religious fellowship with community development activities. It has churches in 26 states of Nigeria.

ENABLE provided COCIN with capacity building programs for project implementation and sustainability, incorporated gender into all programs and project management, and used gender-integrating strategies. A woman's right to empowerment and women's legal rights were promoted, human rights of orphans and other vulnerable children were protected, and communities were mobilized for DG and family planning/RH/HIV/AIDS using various proven models.

Under ENABLE, COCIN implemented an array of RH interventions, including:

- Holding seminars and workshops and making home visits with RH messages;
- Training male and female counselors and community-based distributors (CBDs);
- Distributing condoms through CBDs, traditional birth attendants (TBAs), and male counselors;
- Creating an HIV/AIDS unit in the Health Services Department;
- Including HIV/AIDS sensitization talks in 35 Regional Church Councils;
- Affecting change in the church's response to HIV/AIDS;
- Providing care and support for people living with HIV/AIDS and orphans;
- Training more than 600 pastors and their spouses in HIV/AIDS counseling;
- Organizing and conducting talks in villages and church congregations on the benefits of family planning, safe motherhood, child immunization, and sexually transmitted infection (STI) and HIV/AIDS prevention;

- Sensitizing husbands and community and religious leaders on the need to encourage mothers to breastfeed; and
- Networking with other faith-based groups and mobilization for advocacy.

COCIN also conducts numerous DG activities. These include: training community-based advocates (CBAs), community mobilizers, and community and religious leaders to advocate for joint decision making between partners; using CBAs and vanguard of democracy groups to advocate against violence against women; and organizing talks and seminars for community leaders to address socio-cultural barriers to women's participation in politics. The organization also provides training in local governance, conflict management, and leadership.

II. Study Objectives and Conceptual Framework

A. Study Objectives

The study's main objective was to determine if there is a relationship between key reproductive health behaviors and participation in DG activities. The study examined the impact of combining RH education and services and DG activities on the RH knowledge, attitude, and behaviors of women of reproductive age in the COCIN project sites in Plateau State, Nigeria. The expected outcome of the study was that programs linking family planning (FP), RH and DG activities are more effective in increasing the use of FP/RH services than non-linked programs.

B. Women's Empowerment in an Enabling Environment

Women's empowerment is a process that expands opportunities or choices for women and increases their capability to exercise those choices. The outcome of the empowerment process for individual women is greater control over the material and social resources from which power is derived and a greater sense of personal self-worth. Because a diverse set of actors exercise power in women's lives, women's empowerment in one domain does not necessarily lead to empowerment across all domains. For example, while a woman may be successful as a market trader, this may not imply that she has a voice in important decisions in her household. Yet, at least in theory, the perception of self-assurance that women gain during the empowerment process has implications for many aspects of their lives.

The empowerment process operates at numerous intertwined levels that may enhance or weaken each other. For example, recent research in Nigeria has shown that educated women have similar reproductive preferences regardless of the gender-equity context, whereas the preferences of women with no education are strongly influenced by the gender-equity context where they reside (Kritz et al, 2000). As a result, empowerment at the individual level often is dependent on the existence of an *enabling environment*. This is a context of expanded rights and opportunities that include full political participation, access to health care and education, economic self-reliance, ownership and property inheritance, and the elimination of gender-based discrimination and exploitation (Dixon-Muller and Germain, 2001).

C. Evaluation Plan

The evaluation plan for the COCIN study has three components, each of which addresses a different facet of the overall project assessment.

1. The process and output evaluation documents the nature, quantity, and coverage of project activities. This component identifies the interventions and their objectives. It also supports the interpretation of the survey results.

2. The results evaluation measures the extent to which women residing in the intervention areas compared with women residing in non-intervention areas are empowered to improve their reproductive health, and have better reproductive health knowledge and behavior.

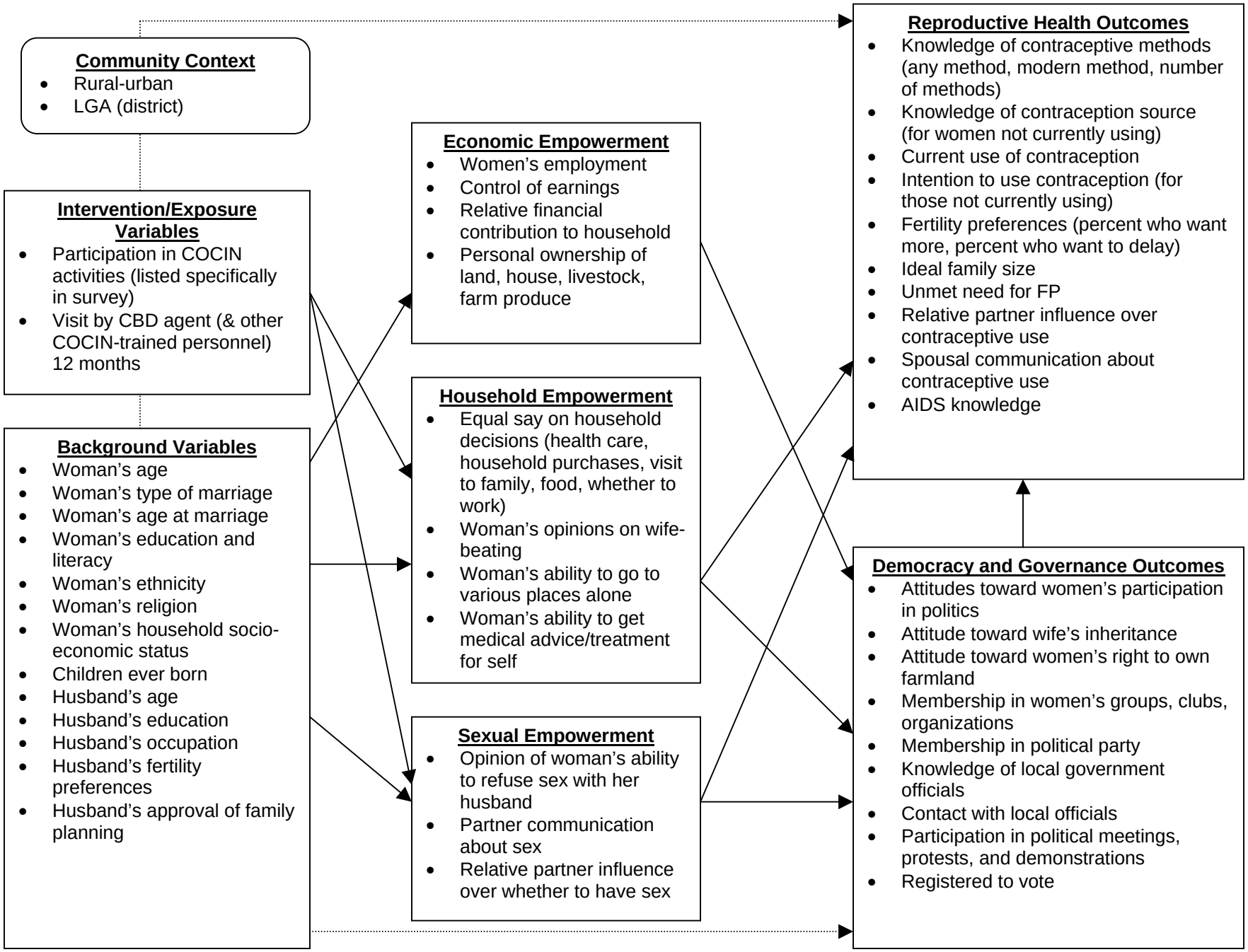
   The most straightforward way to implement this component is to select one local government area (LGA) in a state where both RH and DG activities were conducted and one LGA in a state where no ENABLE interventions were conducted. The non-intervention LGA needs to be as comparable as possible to the intervention LGA along measurable dimensions such as the health infrastructure, rural-urban composition, ethnicity, religion, and economic activity. A household survey is then conducted in each LGA and the results compared on women's empowerment and RH outcomes.

3. The statistical analysis analyzes the extent to which the various dimensions of women's empowerment are related to RH outcomes. Based on the survey data, this component includes the multivariate statistical analyses that quantify the relationship of women's empowerment measures to a range of RH outcomes.

D. Conceptual Framework: RH/DG Linkages

See Figure 1 to review the conceptual framework.

Figure 1: Conceptual Framework: RH/DG Linkages



III. Study Methodology and Area

Study Design

The study approach was quasi-experimental. Four LGAs (Bokkos, Langtang-South, Pankshin, and Quan'pan) were used for the implementation of the RH and DG linkages study in Plateau State, and within them five Local Church Councils (LCCs) per LGA were selected for the study. To measure the impact of combining RH and DG on FP services, educational interventions in RH/DG were ear-marked for Bokkos, Langtang-South was used for RH interventions, interventions in DG were implemented in Pankshin, and Quan'pan served as the control for the study where no intervention activities took place. Table 1 illustrates the research designs.

Table 1: Study Design

Integrated Reproductive Health and Democracy and Governance Community: Bokkos LGA	**Reproductive Health-Only Community:** Langtang-South LGA
No Intervention – Control Community: Quan'pan LGA	**Democracy and Governance-Only Community:** Pankshin LGA

Interventions

1. Integrated (RH/DG Combined) LGA

   In the integrated LGA, trained community health workers and providers (CBDs, TBAs, and male counselors) provided RH/FP services to community members. These services included: distribution of family planning commodities (oral pills and condoms), counseling, provision of information, referrals to clinics, and education and communication messages and materials.

   Community health workers were encouraged to create awareness of the benefits of family planning, safe motherhood, child survival, immunization, and prevention of STI/HIV/AIDS through advocacy visits to community leaders (religious, traditional, women, government officials) and gatekeepers. Rallies, sensitization activities and special events also were held to inform community members about the benefits of reproductive health services.

   The IEC materials used by community workers and in the clinics integrated health and democracy and governance themes, such as discussions during home visits, group talks, interpersonal communication, and posters comparing the benefits of women's involvement in decision making to show the importance of reproductive health.

   In addition, selected leaders of COCIN went to Uganda in March 2000 to study the roles of religious institutions in the crusade against HIV/AIDS.

2. Reproductive Health-Only LGA

   In the RH-only LGA, health information and services were provided through community distributors. Initially this included promoting oral contraceptives and condom use, pre- and post-natal care, and treatment of common ailments by traditional birth attendants. The program later expanded to include information and counseling on HIV/AIDS services. Community health workers (CBDs and TBAs) and clinical service providers also made referrals to designated referral clinics.

3. Democracy and Governance-Only LGA

   In the democracy and governance-only LGA, civic education activities were provided on the elections and electoral processes that included voting procedure and voter education. Advocacy visits were made by COCIN staff and trained CBAs and mobilizers to the religious and community leaders to advocate for joint decision making between partners. CEDPA and other NGO staff provided training to community members on conflict management, leadership, political candidacy, social mobilization, and transparency and accountability. The activities also included the formation of coalitions and networks, such as democracy watch groups, 100 Women Groups, and vanguards of democracy, with the purpose of engaging local and elected representatives to advocate and demand for transparency, accountability, and the inclusion of women in the political process.

4. No Intervention (Control) LGA

   In this LGA, COCIN had no program activities. However, it should be noted that during the 24-month implementation period, the government and other donor agencies executed programs that CEDPA and COCIN could not restrict. Such activities included voter mobilization and education, particularly during the last election cycle.

Due to civil unrest and inter-tribal conflict, some communities' members were displaced and relocated to other communities. One that was affected was the RH-only LGA, which witnessed civil strife for about 12 months. Some of the displaced people were relocated to other LGAs where their relatives live.

Study Area

Plateau State is one of the Federal Republic of Nigeria's 36 states. The state derived its name from the Jos Plateau, the ubiquitous and predominant geographical landscape in this part of Nigeria. The city of Jos is the state capital. The state has undulating highlands characterized by hills ranging from 500 to 600 meters above sea level, and artificial hill locks and mining paddocks are found all over the state. Plateau State is located in the middle belt region and is bordered in the Northwest by Kaduna State, in the Northeast by Bauchi State, in the Southwest and West by Nasarawa State, and in the Southwest by Taraba State.

The 1991 national census shows about 2.56 million people living Plateau State. The projected population for 2003 is 3.59 million, with an annual growth rate of 2.8 percent. The state is

relatively sparsely populated, with an average population density of 61 persons per square kilometer (sq.km.), compared to the national population density of 96 persons per sq.km. (Ariyo, 2000). Apart from the Jos metropolitan area (comprising Jos North, Jos East, and Jos South LGAs), where population densities are as high as 391 persons per sq.km., most other parts of the state, including the study areas, have relatively low population densities that range from 40 to 125 persons per sq.km. The low population density of the study areas can be attributed largely to the widespread presence of undulating terrain, which is interspersed with hills. Indeed, while the pre-colonial settlement pattern in most areas of Plateau State was characterized by nucleated villages located on the tops of hills for defense and protection, many of the settlements today, including those in the study areas, are dispersed along the foothills.

The study areas, Bokkos, Langtang-South, Pankshin, and Quan'pan LGAs (see map, Figure 2), were created at different times between 1976 and 1996, when political administrative boundaries were realigned or adjusted. For example, Bokkos LGA was carved out of Mangu LGA. Also, while Langtang-South LGA was created in August 1991, Quan'pan LGA came into existence in 1989. Table 2 shows the individual populations of the study areas, based on figures from the National Population Census in 1991.

Figure 2: Map of Plateau State, Nigeria

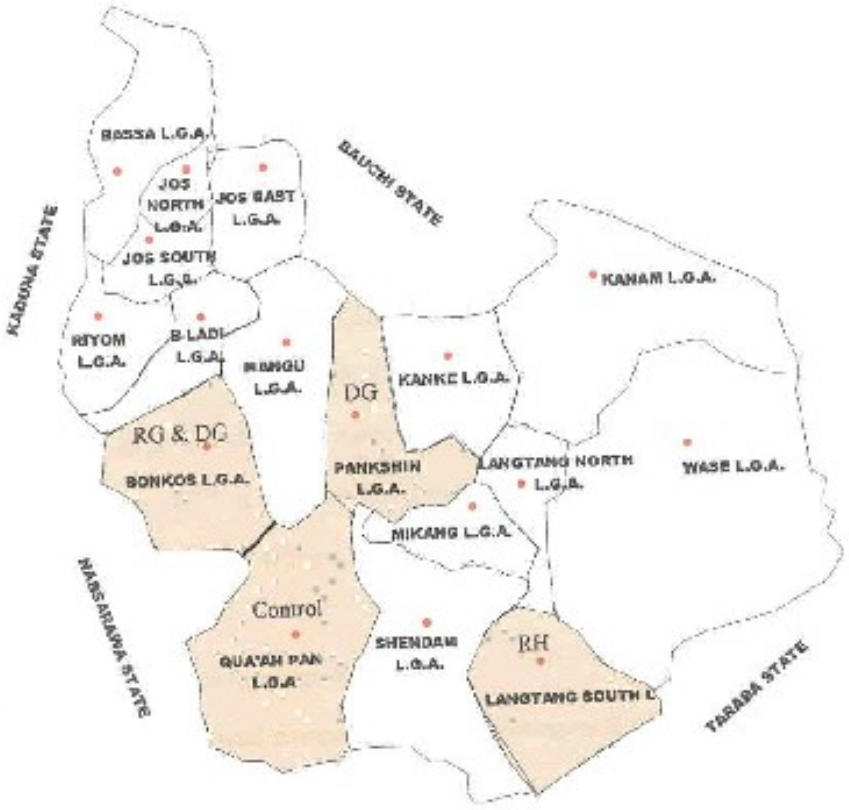


Table 2: Populations of the Study Areas (1991)

Local Government Area	Male	Female	Total
Bokkos	45,530	49,688	95,218
Langtang-South	23,037	24,071	47,108
Pankshin	57,661	57,502	115,163
Quan'pan	69,271	71,811	141,082

Source: National Planning Commission (1993) Census 1991: National Summary

Apart from the fact that Quan'pan LGA and Langtang-South LGA had, and perhaps still have, the highest and lowest populations in the study areas, it is apparent from Table 2 that female population outstrips male population in all of the study areas, except for Pankshin LGA.

Approximately three-quarters of Plateau State's population lives in rural areas, and one-fourth in urban areas, based on data from the 1991 census (National Population Commission, 1998: 36). In the study areas, very few urban areas exist, including local government headquarters and a few towns.

In Plateau State, the mean household size, according to the 1991 population census, was 5.7 persons, in comparison to Nigeria's average of 4.9 persons (National Population Commission, 1998: 82). In line with the foregoing observation, a general household survey by the Federal Office of Statistics also revealed that household sizes ranged from 4.8 persons in Pankshin to 6.1 in Langtang-South. Most households (93.9 percent) are also headed by males in Plateau State; this is likely to be the case in all of the study areas. In terms of accessibility to satisfactory toilet facilities, refuse disposal systems, and electricity, a significant proportion of households in the study areas are disadvantaged. For example, 99.5 percent of households in Quan'pan LGA and 87.9 percent of households in Pankshin LGA were without electricity in 1993/94.

The poverty headcount by the Federal Office of Statistics showed that in 1996/97, there were 34.1 percent, 40.9 percent, and 25.0 percent non-poor, moderately poor, and extremely poor people in Plateau State, respectively (FOS, 1999: 88). Thus, poverty is widespread throughout the state, including the study areas.

Sampling Procedures

To select respondents for the survey, a multi-stage probability sampling procedure was adopted using the enumeration maps prepared by the National Population Commission for the 1991 census. Each study LGA was stratified into Local Church Councils (LCCs) that reflect the COCIN hierarchical administrative structure. Five LCCs were randomly selected at the first stage, based on where project interventions were implemented. The number of LCCs varied from one LGA to another as well as the population size. Each LCC comprises between four to six villages with several congregations that are called church councils.

In each LCC, supervisory areas (SAs) were randomly selected at the second stage. Enumeration areas (EAs) were selected within the SAs at the third stage. Ten EAs were randomly selected

within each LGA. After the selection of EAs, household listings were created to determine the number of people in each EA and the population of women aged 15 to 49 years that are married or living with a male partner.

Having completed the house listing exercise in all the selected EAs and LCCs, the respondents (women aged 15 to 49 years, ever-married or lived-in-union) were systematically selected for an interview. The systematic sampling method involves the selection of the nth subject, item, or person from serially listed population subjects or units (where n is any number, usually determined by dividing the population (N) by the required sample size). Thus, from the house listing exercise, the total number of eligible respondents in each EA was determined. This number was divided by 50 – the required sample size per EA to determine the sampling interval.

Since the number of eligible respondents varied from one EA to another, the sampling interval (N) adopted in each EA varied from one to three. However, it should be emphasized that where the required sample size of 50 for a particular EA was not attained, the interviewers were instructed to move to the adjacent EA to the right of the originally selected EA. This systematic random sampling method was used because it yields an even coverage of the sampling frame.

Since the LCCs and the villages under them are different sizes, samples were chosen from EAs that fall within the program LCCs. The National Population Commission delineated the country into SAs and EAs in 1991. Thus, the EA maps used to construct a sample for the survey were obtained from the NPC.

Overall, 2,000 women were interviewed in the four LGAs – 500 per LGA. The process used for selecting individual respondents is described below.

Sampling Framework

EAs within the program activity areas were selected randomly, and in each EA a fixed number of 50 women was interviewed. The two stages observed in the selection of the respondents are described below.

Stage 1: Random Selection of EAs

- All the EAs that fall within COCIN program areas in each LGA (within the five LCC areas) were listed.
- Ten EAs per LGA were randomly selected.
- In each LGA, 500 ever-married or lived-in-union women were interviewed for the survey – 50 women per LGA.

Stage 2: Selection of Respondents

After the reconnaissance visits to the sample EAs, the household listing exercise was conducted. This involved the interviewers' group going to the households in the selected EAs and making a quick list of the following items in a simple, one-page household listing form:

- Address of the household
- Sex of the head of the household
- Number of people living in the household
- Number of males and females in the household
- Number of females between the ages of 15 to 49 in the household
- Number of these women that are ever-married or lived-in-union
- Ages of these women

The household listing exercise was done in all the selected LCCs. After the exercise, women were systematically selected within the EA until the required sample size of 50 women between the ages of 15 and 49 who are ever-married or lived-in-union was attained.

Questionnaire Design

The individual questionnaire was structured to reflect the research problem and objectives and provide adequate information to test the study hypotheses. Background information on the respondents, such as age, religious affiliation, educational attainment, age at marriage, occupation, and position among wives, that relate to the study objectives were canvassed.

The women's individual questionnaire contained eight sections: Household Characteristics; Respondent's Background; Reproduction; Contraception; Marriage and Sexual Activity; Fertility Preferences; Husband's Background and Woman's Work; and Household Decision Making and Political Participation. For example, the first section of the questionnaire related to the household facilities and focused on the availability of radio and television, source of drinking water, toilet facilities, and wall and floor materials. The section on the respondent's background elicited information on the respondent's age, educational status, literacy level, religion, and economic status.

Questionnaire Administration

Forty interviewers and eight supervisors were recruited from the Federal Office of Statistics and National Population Commission. A five-day training session on the principles of interviewing was organized in Jos Town. During the training session, the interviewers were instructed on the link between household and individual schedules. They also were taught how information in the household schedule could be used to verify information in the individual schedule and vice versa. The use of the household roster to determine female respondents who were eligible for individual interviews was emphasized. Other issues, such as creating a friendly interview setting, restating questions, following instructions, and estimating ages, were also stressed at the training.

The training also involved practice interviews among the interviewers as well as field trial interviews in the community. Interviewers were also trained on basic interview techniques: how to gain entry into a household, how to ask specific questions, and how to wrap up interviews.

After the daily data collection, supervisors reviewed and edited the completed questionnaires for completeness and internal consistency. If any mistake was observed, the enumerator concerned was

sent back to the household where the questionnaire was administered to correct the identified mistakes.

The survey instruments were translated into the local language to ensure that there was uniformity in the way the interviewers asked the respondents questions. The interviewers were trained to administer the questionnaire in the local language whether or not the respondents could communicate in English. For effective administration of the questionnaires, 12 field assistants were employed (three supervisors and nine enumerators) for three months.

Quality Control: The research teams established appropriate checks to ensure the collection of high-quality information and data for analytical purposes. All supervisors made rounds in each settlement to observe and/or actively participate in data gathering. Each evening, questionnaires were vetted and those not properly completed were returned to the interviewers concerned for repeat calls. The integrity of the study was also maintained by reducing the "learning effect" to the barest minimum, especially for questionnaire administration.

Advocacy: Before the actual data collection, team supervisors, with CEDPA and COCIN staff, met with religious leaders (particularly the COCIN minister in charge of the selected LCC), traditional chiefs, opinion leaders, and elected officials to sensitize them about the objectives and strategies of the study and to solicit their cooperation in the implementation of the study. This sensitization process did not impinge on the integrity of the data gathered.

Data Analysis: The first task was to code the open-ended questions in the questionnaire by preparing a code-list generated from the responses received. Codes were then assigned to the various responses using this codebook. The study made use of the EPI-INFO package as a data entry tool because of its auto-coding and error checking features, and has the capability of reducing entry errors.

The questionnaires were thoroughly scrutinized for consistency errors. Thereafter, the data were put into the Statistical Package for the Social Sciences (SPSS), which was used to generate percentages and averages and to carry out bivariate analyses. Descriptive statistics such as simple frequency and percentage distribution, as well as cross-tabulations, also were employed in data presentation. Logistic regression also was used for the multivariate analysis.

In examining the linkages between women's reproductive health behaviors and their participation in civil society and the differences among the four LGAs, five scales were generated from various items on the questionnaire:

1. Mobility

   Because seclusion is thought to deny women opportunities to participate in income-generating activities and to limit their access to resources, services, and information, a measure on mobility is included. This indicator is based on a series of questions on whether and under what circumstances – how frequently and accompanied by whom – women are able to go out of the house to purchase major household items, visit friends and relatives, visit health facilities, and attend worship services. A continuous

index variable was constructed ranging from zero to six, based on the combined responses to these questions, allocating high for women's scores to be between five and six, three to four for moderate, and low for women that score less than three.

2. Household Decision Making

A woman's overall input in household decisions is a key indicator of her power and importance within the family. Six questions were asked to determine women's preference regarding who should make decisions on health care; purchase of household items; visit to family members; food to cook; and whether the respondent should work. Responses available were: respondent, husband/partner, respondent and husband/partner jointly, someone else, respondent and someone else jointly, and decision not made/not applicable. However, the decision-making index was reclassified to ask high, moderate, and low participation in decision making, allocating scores of four to six for high level, one to three for moderate, and zero for low participation in decision making.

3. Household Socio-Economic Status

The measure of socio-economic status is based on ownership and functionality of relevant household facilities. The facilities included in the index were electricity, radio, television, refrigerator, generator, bicycle, motorcycle, and car. Those in a higher socio-economic class are those who own three of the facilities and above; the moderate social class owns two items; and those who own zero to one are classified as low class status.

4. Sexual Empowerment

Nigerian women are usually expected to accept sexual advancements made by their husband or partner under any conditions. However, due to the implementation of greater education and gender-sensitive activities, respondents were asked whether a wife is justified in refusing to have sex with her husband when: a) husband has a sexually transmitted infection; b) husband has sex with women other than his wives; or c) wife has recently given birth and/or is tired or not in the mood. The woman is regarded to be sexually empowered when she scores between one and four, while those with a score of zero are considered to be sexually unempowered.

5. Violence Against Women

An index was generated from items relating to perception on the justification for a husband to beat or hit his wife. A score of zero was given if the respondent had positive perception on justification of wife beating; otherwise a score of one to six was given to women who are opposed to wife battery.

Table 3 shows the respondents' socio-economic and demographic characteristics, as follows:

- The majority of respondents was married and had a mean age of 32.5 years, that is to say, within the active segment of the population.

- The four LGAs were predominantly Christian (Catholics, COCIN, Pentecostal, and Protestants). Muslims constituted one-third of the respondents in Quan'pan LGA.

- The average age at which the majority of the respondents started living with a man was 19 years. The average age when the respondents started living with a man did not vary significantly by LGA, although respondents in Quan'pan LGA married earlier than their counterparts from other LGAs.

- Marriages are universal and relatively stable in the four LGAs. Roughly nine in ten respondents said they were currently married: 92 percent in Bokkos, 94 percent in Langtang-South, 92 percent in Pankshin, and 89 percent in Quan'pan. Among the respondents, less than ten percent reported being either separated or divorced, except in Quan'pan where it reached 11 percent.

- The study areas have a relatively high level of educational attainment compared with the national standard, except in Quan'pan where about 51 percent of the female respondents reported having no education. Overall, husbands or partners of the respondents had higher educational attainment than the women did.

- Less than two-fifths of the respondents listened to the radio daily, except in Bokkos where 56.5 percent reported daily exposure to radio messages. Nearly half (46%) of the respondents in the RH-only communities had not listened to the radio at all in the past few months. The low level of exposure to radio might be attributed to the predominantly rural area.

- The COCIN CBDs visited less than one-quarter of the respondents in the RH-only and RH/DG combined LGAs during the past 12 months. The exposure to CBD activities in the past 12 months by those in the DG-only and control communities could be attributed to the displacement or relocation of families affected by communal conflict or violence in Langtang-South LGA and nearby Wase LGA.

However, it should be noted that the so-called control area contained respondents who were somewhat less educated, of lower socio-economic status, and less likely to be currently married.

Table 3: Percentage distribution of respondents by socio-economic characteristics according to local government areas

Characteristics	RH and DG (Bokkos)	RH-Only (Langtang-South)	DG-Only (Pankshin)	Control (Quan'pan)	Total
Age group					
Less than 25 years	20.8	17.5	15.6	22.9	19.3
25-34 years	37.1	40.4	37.0	39.9	38.6
35 years and above	42.0	42.1	47.3	37.2	42.1
Place of residence					
Rural	86.6	100.0	60.0	99.8	86.6
Urban	13.4	-	40.0	0.2	13.4
Religious affiliation					
Catholic	7.9	30.3	40.6	32.3	27.8
COCIN	54.6	44.9	46.3	26.5	43.0
Other Christians	14.4	17.1	10.7	3.8	11.5
Islam	22.5	0.2	2.0	36.6	15.3
Traditional and no religion	0.6	7.5	0.4	0.8	2.3
Educational attainment					
None	36.8	36.8	37.4	50.6	40.4
Primary	26.8	35.2	28.2	28.2	29.6
Secondary	28.8	21.2	27.4	17.4	23.7
Post-secondary	7.6	6.8	7.0	3.8	6.3
Marital status					
Currently married	91.6	94.2	91.8	88.7	91.6
Previously married	8.4	5.8	8.2	11.3	8.4
Husband's educational attainment					
None	36.4	27.6	26.2	39.6	32.5
Primary	17.4	27.0	26.2	20.8	22.9
Secondary	25.8	25.0	29.2	22.0	25.5
Post-secondary	19.6	20.0	17.0	16.6	18.3
Don't know	0.8	0.4	1.4	1.0	0.9
Husband's age group					
Less than 30 years	26.0	18.3	17.1	21.8	21.1
30-39 years	68.8	80.6	81.1	77.0	76.4
40 years and above	5.1	1.1	1.8	1.2	2.5
Frequency of radio listening					
Daily	56.5	25.5	38.2	31.8	38.0
Once in a while	25.3	28.5	28.6	30.6	28.3
Not at all	18.2	46.0	33.3	37.5	33.8
Visited by project CBD					
Yes	24.8	20.2	10.6	5.0	15.2
No	75.2	79.8	89.4	95.0	84.9
Household socio-economic status					
Low	39.2	42.4	47.7	53.6	45.7
Moderate	25.6	42.2	25.9	29.4	30.8
High	35.3	15.4	26.5	16.9	23.6
TOTAL %	100.0	100.0	100.0	100.0	100.0
(n)	(500)	(500)	(500)	(500)	(2000)

Table 4 shows the percentage distribution of the respondents according to reproductive health behavior, women's perceived status, and exposure to DG program activities indicators. With regard to women's views on who should make decisions on health care, purchase of household items, and visits to relatives, less than 30 percent consider it to be a matter of joint input by husband and wife, while a significant proportion consider it to be solely the husband's (or someone else's) prerogative. However, less than one-fifth of the women consider it to be a prerogative of the wife alone, except in RH/DG combined communities.

Fewer than nine percent of the women are currently using modern contraceptive methods, except in the RH/DG combined LGA where 12 percent are currently using contraception. Nearly half (46%) of the women intend to adopt contraception in future.

Fewer than one in three respondents have participated in democracy and governance activities, except in Langtang-South where 34 percent have participated in DG activities. Civil disturbances that characterize the study area may have affected their reported participation. Several families were displaced or relocated to other communities.

Clearly, substantial variability exists within the study area with regard to women's mobility, with almost 67 percent of the respondents considering themselves to be substantially independent, and an additional 17 percent exercising a moderate range of mobility. The percentage of women who reported a high level of mobility was recorded among the RH/DG combined LGA. Furthermore, a significant proportion of the study population consider themselves to be sexually empowered, with 83 percent of those in the RH/DG combined communities considering themselves empowered, compared with 61 percent in the control communities.

Table 4: Percentage distribution of respondents by empowerment indicators, by local government areas

Characteristics	RH and DG (Bokkos)	RH-Only (Langtang-South)	DG-Only (Pankshin)	Control (Quan'pan)	Total
Mobility index					
Low	6.4	13.7	22.0	19.3	15.4
Moderate	12.9	13.3	20.0	22.3	17.2
High	80.7	72.9	58.0	58.4	67.4
Household decision-making index					
Respondent alone	22.0	9.9	13.8	12.1	14.4
Husband and wife	21.7	32.9	37.1	22.8	28.6
Others	56.3	57.2	49.1	65.1	56.9
Sexual empowerment index					
Yes	83.4	66.3	74.0	60.6	71.1
No	16.6	33.7	26.0	39.4	28.9
Violence against women justified index					
Yes	62.3	76.4	67.5	42.0	62.1
No	37.7	23.6	32.5	58.0	37.9
Exposure to DG activities					
Yes	30.2	34.0	28.8	15.6	27.2
No	69.8	66.0	71.2	84.4	72.9
Current use of modern family planning					
Yes	12.0	6.2	9.4	6.8	8.6
No	88.0	93.8	90.6	93.2	91.4
Intended future use of contraception					
Yes	53.1	43.2	45.8	40.3	45.6
No	33.5	48.5	29.6	40.0	37.8
Don't know	13.4	8.3	24.6	19.7	16.6
TOTAL %	100.0	100.0	100.0	100.0	100.0
(n)	(500)	(500)	(500)	(500)	(2000)

The results shown in Table 5 shed light on several factors that influence the participation of respondents in DG activities, as well as visits by CBDs. The study results reveal that age of respondents, educational attainment, religious affiliation, exposure to radio, household socio-economic status, mobility, contraceptive status, intention to use family planning in the future, and study area determine contact with CBDs. For instance, those who are COCIN members are more likely to have been contacted by CBDs than their counterparts who are Christians of other denominations or Muslims. In addition, women who live in Bokkos and Langtang-South are more likely to have been visited by CBDs than their counterparts in Pankshin and Quan'pan. This is understandable because Bokkos and Langtang-South are places where CBDs were trained to provide reproductive health services. It is possible that some of the women in Pankshin and Quan'pan who reported contact with CBDs had been displaced by the civil disturbances and had previously resided in other LGAs.

Regarding participation in DG activities, most factors that influence CBD contact also influence the participation of women in DG activities. Table 5 indicates that educational attainment, religious affiliation (being a COCIN member), place of residence (residing in urban area), exposure to radio (daily), mobility, and high socio-economic status encouraged participation of the respondents in DG activities.

Logistic regression is used here for the multivariate estimation due to the binary nature of the dependent variables (visited by CBD – yes/no; and participated in DG activities – yes/no). This approach permits a determination of the extent to which background factors and exposure variables, as well as women's perceived status, act as determinants on the dependent variables. Therefore, Table 9 presents the results in a less complex form, showing the relative size of significant coefficient as well as its relative strength. A single asterisk indicates a relatively small effect, whereas two asterisks indicate an extremely strong effect. Overall, several factors such as age, religious affiliation, exposure to radio, study area, and mobility remain significant determinants of contact with CBDs. However, religious affiliation, place of residence, exposure to radio, husband's educational attainment, and mobility remain important determinants of participation in DG activities.

Table 5: Percentage distribution of respondents participating in RH and DG activities, by selected characteristics

Characteristics	Program Participation	
	Visited by CBDs/TBAs	Exposure to DG Activities
Age group		
Less than 25 years	10.5**	24.1
25-34 years	15.1	29.8
35-49 years	17.4	26.5
Place of residence		
Rural	15.5	26.4
Urban	13.1	31.7
Religious affiliation		
Catholic	9.1**	20.5**
COCIN	24.6	41.2
Other Christians	11.5	21.6
Islam	3.6	4.6
Traditional and no religion	8.7	21.7
Educational attainment		
None	10.6**	19.4**
Primary	15.4	27.0
Secondary	19.2	36.3
Post-secondary	27.8	42.9
Marital status		
Currently married	15.3	27.7*
Previously married	14.3	21.4
Husband's educational attainment		
None	9.7**	20.6**
Primary	17.3	29.8
Secondary	14.5	24.9
Post-secondary	23.0	38.8
Frequency of radio listening		
Daily	17.0**	31.7**
Once in a while	18.6	31.8
Not at all	10.5	18.8
Mobility index		
Low	6.3**	16.1**
Moderate	12.1	24.3
High	18.2	30.5
Household decision-making index		
Others	13.8	25.7*
Husband and wife (joint)	16.0	31.3
Wife alone	18.7	25.0
Household socio-economic status		
Low	12.7*	22.7**
Moderate	16.4	29.5
High	18.2	34.0
Sexual empowerment index		
Yes	17.4**	28.7**
No	9.5	23.2
Current use of modern contraception		
Currently using	30.2**	42.4**
Not using	13.7	25.7

Intended future use of contraception		
Yes	22.3**	27.8
No	8.1	25.2
Don't know	7.6	26.5
Study area		
RH and DG	24.8**	30.2**
RH-only	20.2	34.0
DG-only	10.6	28.8
Control	5.0	15.6

*p<.05, **p<.01

Current Use of Contraception

Table 6 shows the percentage distribution of current users of modern methods of FP according to selected background characteristics and women's perceived status indicators by their educational attainment. The study found that 8.6 percent of the respondents were current users of modern methods, in contrast to the 1999 Nigeria Demographic and Health Survey, which reported a 10.9 percent current usage rate by married women in the Central Region.

Current use of modern methods of FP is related to the level of education attainment. The data suggest that women with a secondary education and above are about two times as likely as women with no education or a primary education to be currently using a contraceptive method. For instance, current use of a modern method is highest among women who had a secondary education and above (13.3%) as compared with those who had below a secondary education (6.7%).

Controlling for education, factors associated with modern contraceptive use are: current age, religious affiliation, place of residence, exposure to radio, household socio-economic status, mobility, contact with CBDs, exposure to DG activities, husband's educational level, and study area (Table 6).

The results indicate that current use of family planning varies by religious affiliation. Women of the COCIN denomination are most likely (10.6%) and Muslims least likely (3.3%) to be currently using family planning. This is evident across all educational levels. Place of residence was also found to be associated with current contraceptive use. While 24 percent of women with a secondary education or higher are currently using a modern method, only 11 percent of their rural counterparts reported to be currently using contraception.

Table 6: Percentage distribution of ever-married women who are currently using modern contraceptives, by selected characteristics and education

Characteristics	Educational Attainment	
	Below Secondary	Secondary and Above
Age group**		
Less than 25 years	2.2	8.7
25-34 years	5.3	13.2
35-49 years	9.4	16.1
Place of residence**		
Rural	5.5	10.7
Urban	15.5	23.9
Religious affiliation**		
Catholic	4.5	11.0
COCIN	10.6	13.8
Other Christians	5.3	16.0
Islam	3.3	10.3
Marital status		
Currently married	6.8	13.6
Previously married	5.0	6.4
Husband's education		
None	5.6	12.1
Primary	7.1	10.4
Secondary	8.0	9.9
Post-secondary	7.7	17.8
Frequency of radio listening**		
Daily	9.7	13.7
Once in a while	7.0	14.7
Not at all	4.6	8.8
Mobility index*		
Low	3.8	7.4
Moderate	4.7	10.6
High	8.1	14.5
Household decision-making index*		
Others	5.9	12.6
Husband and wife (joint)	5.8	14.9
Wife alone	11.9	12.2
Household socio-economic status**		
Low	4.1	9.0
Moderate	8.7	10.0
High	9.8	19.4
Sexual empowerment index		
Yes	6.3	13.4
No	7.8	11.0
Study area**		
RH and DG	11.0	13.7
RH-only	4.2	11.4
DG-only	5.2	17.4
Control	6.6	7.5
Visited by CBD**		
Yes	14.7	20.6
No	5.5	11.2
Exposure to DG activities**		
Yes	8.8	19.9
No	6.0	9.1

*p<.05, **p<.01

An important factor that can stimulate the use of contraception is freedom to access FP services. It could be observed that current use of contraception is higher for women with high mobility, daily exposure to radio, visits by CBDs, participation in DG activities, high household socio-economic status, and decision-making empowerment. Table 8 indicates that household socio-economic status, educational level, current age, marital status, visits by CBDs, mobility, and sexual empowerment have a significant explanatory power on the current use of contraceptive methods. Consequently, there is no significant association between current use of a family planning method and religious affiliation, place of residence, exposure to radio, husband's educational level, exposure to DG activities, and opposition to violence against women.

Intention to Use Family Planning in the Future

In addition to questions on the use of contraception, respondents who were not using a method at the time of the survey were asked to indicate whether they intend to use a method in the future to avoid becoming pregnant. Intention to use family planning in the future varies by educational level. About 40 percent of the non-users who have below a secondary education expressed the desire to use a contraceptive method in the future, while 58.4 percent of those with a secondary education or higher expressed the desire to use a method in the future. Table 7 shows that there is an inverted U-shaped association between age and the proportion of non-users who intend to use a method in the future. Women aged 25 to 34 years are more likely than their respective counterparts to use a method in the future. While women in urban areas are more likely than their rural counterparts to use a method in the future, intention to use a method in the future does not vary by marital status and exposure to DG activities. Those who have been visited by CBDs are more likely to express their desire to use a family planning method in the future than their counterparts who have not been visited by CBDs. Husband's educational attainment and intention to use a method in the future are positively related. Other factors that have positive association with the intention of using a method in the future are: mobility, sexual empowerment, and household decision-making empowerment.

Logistic regression analysis was used to determine the net effect of background and women's position indicators on the desire to use a method in the future. Table 8 (columns 4 and 5) indicates that current age, educational attainment, religious affiliation, exposure to radio, exposure to DG activities, visits by CBDs, and mobility have a significant explanatory power on the intention to use a family planning in the future.

Table 7: Percentage distribution of ever-married women who intend to use modern contraceptive in the future, by selected characteristics and by education

Characteristics	Educational Attainment	
	Below Secondary	Secondary and Above
Age group**		
Less than 25 years	39.4	56.8
25-34 years	46.6	59.7
35-49 years	34.8	59.2
Place of residence**		
Rural	39.1	58.6
Urban	44.8	57.9
Religious affiliation**		
Catholic	38.2	49.1
COCIN	43.7	63.3
Other Christians	46.6	65.4
Islam	32.4	39.1
Marital status		
Currently married	40.5	58.9
Previously married	32.1	51.6
Husband's education**		
None	28.3	42.6
Primary	49.3	45.8
Secondary	48.2	60.9
Post-secondary	43.5	65.5
Frequency of radio listening**		
Daily	41.7	57.8
Once in a while	42.4	61.8
Not at all	36.1	57.5
Mobility index**		
Low	27.8	44.9
Moderate	33.7	57.0
High	44.4	61.2
Household empowerment index*		
Others	38.8	54.1
Husband and wife (joint)	40.9	60.8
Wife alone	41.0	67.7
Household socio-economic status		
Low	37.1	63.4
Moderate	40.7	51.1
High	43.7	59.3
Sexual empowerment index*		
Yes	42.0	61.9
No	34.5	48.0
Study area**		
RH and DG	45.9	64.6
RH-only	36.9	57.8
DG-only	40.6	56.0
Control	36.8	52.4
Visited by CBD**		
Yes	65.8	75.8
No	36.3	54.1
Exposure to DG activities		
Yes	39.0	58.1
No	40.0	58.7

*p<.05, **p<.01

Table 8: Logistic regression of the effects of selected background characteristics, sexual empowerment, mobility, and violence against women on current and future intention to use modern family planning methods

Characteristic/Measures	Currently Using		Intending to Use in the Future	
	Coefficient (B)	Exp (B)	Coefficient (B)	Exp (B)
Age	**0.039**	**1.040****	**-0.021**	**0.979****
Respondent's educational attainment				
None	Ref.		Ref.	
Primary	-0.675	0.509	-0.772	0.462**
Secondary	-0.355	0.701	-0.331	0.718
Post-secondary	-0.171	0.843	-0.150	0.861
Religious affiliation				
Catholic	Ref		Ref.	
COCIN	-0.205	0.814	0.198	1.219
Other Christians	0.251	1.285	0.508	1.662*
Muslim	0.268	1.308	0.602	1.826*
Place of residence				
Rural	Ref.		Ref.	
Urban	-1.203	0.300	-0.278	0.757
Marital status				
Currently married	Ref.		Ref.	
Previously married	0.845	2.327*	0.088	1.092
Husband's educational level				
None	Ref.		Ref.	
Primary	-0.276	0.759	-0.504	0.604*
Secondary	-0.292	0.747	-0.022	0.979
Post-secondary	-0.091	0.913	-0.048	0.953
Frequency of listening to radio				
Daily	Ref.		Ref.	
Once in a while	0.028	1.028	0.132	1.141
Not at all	0.095	1.100	0.315	1.371
Mobility index				
Low	Ref.		Ref.	
Moderate	-0.653	0.521*	-0.537	0.585**
High	-0.379	0.685	-0.230	0.795
Household socio-economic status				
Low	Ref.		Ref.	
Moderate	-0.506	0.603*	0.044	1.045
High	-0.170	0.844	-0.219	0.804
Sexual empowerment index				
Yes	0.417	1.518*	-0.215	0.806
No	Ref.		Ref.	
Opposed to violence against women				
Yes	-0.120	0.886	-0.140	0.869
No	Ref.		Ref.	
Visited by CBD				
Yes	-0.722	0.486**	-1.087	0.337**
No	Ref.		Ref.	
Exposure to program (DG) activities				
Yes	-0.241	0.786	0.446	1.562**
No	Ref.		Ref.	
Constant	-2.026	0.132*	1.634	5.122**
Log likelihood	909.014		1531.045	
Cox & Snell R^2	0.063		0.132	

*p<.05, **p<.01, "Ref."=Reference category

Table 9: Logistic regression of background characteristics, sexual empowerment, mobility, and violence against women on exposure to CBD and DG activities

Characteristic/Measures	Visited by CBD		DG Activity Participation	
	Coefficient (B)	Exp (B)	Coefficient (B)	Exp (B)
Age	**0.026**	**1.027****	**0.007**	**1.007**
Respondent's educational attainment				
None	Ref.		Ref.	
Primary	-0.763	0.466*	-0.384	0.681
Secondary	-0.513	0.599	-0.293	0.746
Post-secondary	-0.384	0.681	-0.109	0.897
Religious affiliation				
Catholic	Ref		Ref.	
COCIN	0.732	2.080	1.351	3.863**
Other Christians	1.597	4.937**	2.212	9.132**
Muslim	0.479	1.614	1.326	3.767**
Place of residence				
Rural	Ref.		Ref.	
Urban	-0.098	0.906	-0.458	0.632*
Marital status				
Currently married	Ref.		Ref.	
Previously married	0.204	1.226	0.056	1.057
Husband's educational level				
None	Ref.		Ref.	
Primary	-0.308	0.735	-0.024	0.976
Secondary	0.268	1.308	0.080	1.083
Post-secondary	-0.195	0.823	-0.306	0.736
Frequency of listening to radio				
Daily	Ref.		Ref.	
Once in a while	0.417	1.517	0.736	2.0888**
Not at all	0.715	2.043**	0.762	2.142**
Mobility index				
Low	Ref.		Ref.	
Moderate	-0.969	0.379*	-0.656	0.519**
High	-0.013	0.987	0.015	1.015
Household empowerment index				
Low	Ref.		Ref.	
Moderate	-0.171	0.843	0.198	1.218
High	-0.075	0.927	0.428	1.534*
Household socio-economic status				
Low	Ref.		Ref.	
Moderate	0.292	1.338	0.021	1.022
High	0.033	1.034	-0.119	0.888
Sexual empowerment index				
Yes	0.470	0.625*	-0.066	0.936
No	Ref.		Ref.	
Opposed to violence against women				
Yes	0.173	1.188	-0.179	0.836
No	Ref.		Ref.	
Study area				
RH and DG only	Ref.		Ref.	
RH-only	1.384	3.990**	0.195	1.215
DG-only	1.160	3.190**	0.531	1.701**
Control	0.267	1.306	0.047	1.048
Visited by CBD				
Yes			0.580	1.785**
No			Ref.	
Constant	-4.299	0.014**	-3.070	0.046**
Log likelihood	1227.951		1706.219	
Cox & Snell R^2	0.127		0.153	

*p<.05, **p<.01, "Ref."=Reference category

IV. Conclusions and Implications for Future Programs

It can be concluded that both individual women's characteristics as well as program exposure variables influence reproductive health behavior. This behavior is a function of both socio-cultural and women's empowerment variables. This study lends support to the idea that participation in democratic activities, such as registration to vote and questioning of political candidates, does lead to a greater sense of independent thinking.

The study also confirms that the dual program variables to human and reproductive health rights are likely to enhance reproductive health behavior above the level achieved by direct family planning interventions alone.

In addition, the study demonstrated that linking health programs with non-health programs leads to women's informed and autonomous decision making by providing participants with tools/skills, positive attitudes, resources, and a supportive environment. It also found that linked programs are associated with greater acceptance of both family planning and greater involvement of women in learning activities related to good democracy and governance norms/values. Furthermore, the study showed that linked programs facilitate women's economic autonomy and lead to personal growth and development, contributing to women's enhanced participation in society.

There are important implications for future programs. The teaching of civic responsibilities and duties within a women's empowerment environment of advocacy and social mobilization should be incorporated into RH programs. However, before basing programmatic decisions on these conclusions, this study should be replicated in other settings with more stable environments.

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ANNEX A: SURVEY QUESTIONNAIRES

The Centre for Development and Population Activities: Nigeria Office
Nigeria Special Studies Questionnaire

IDENTIFICATION

VILLAGE NAME _____

NAME OF HOUSEHOLD HEAD _____

EA NUMBER .....

HOUSEHOLD NUMBER .....

LGA .....

LCC .....

URBAN/RURAL (URBAN=1, RURAL=2) .....

NAME AND LINE NUMBER OF WOMAN _____

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY / MONTH / YEAR
INTERVIEWER'S NAME	_____	_____	_____	NAME
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE	_____	_____		
TIME	_____	_____		TOTAL NO. OF VISITS

*RESULT CODES:

1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 INCAPACITATED
7 OTHER _____ (SPECIFY)

LANGUAGE OF QUESTIONNAIRE **		LANGUAGE OF INTERVIEW **	
NATIVE LANGUAGE OF RESPONDENT TO HH QUEST.**		TRANSLATOR USED	YES .....1 NO 2

INTERVIEWER VISITS
** LANGUAGE CODES: 01 ENGLISH 02 HAUSA 96 OTHER _____ (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____ ☐☐ DATE _____	NAME _____ ☐☐ DATE _____	☐☐	☐☐

SECTION 0. HOUSEHOLD CHARACTERISTICS

INTRODUCTION AND CONSENT

INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a survey in Plateau State about the health of women and their ideas about various subjects. We would very much appreciate your participation in this survey. I would like to ask you about your background, your health, and your opinion on different topics. This information will help us to plan health services and other programs in Plateau State as a whole. The survey will take some time to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED..... 1 ▼ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED.... 2 ⟶END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
20	RECORD THE TIME.	HOUR ..... ☐☐ MINUTES..... ☐☐	

21	What is the main source of drinking water for members of your household?	PIPED WATER PIPED INTO DWELLING .....11 PIPED INTO YARD/PLOT.....12 PUBLIC TAP.....13 WATER FROM OPEN WELL OPEN WELL IN DWELLING .....21 OPEN WELL IN YARD/PLOT .....22 OPEN PUBLIC WELL .....23 WATER FROM COVERED WELL OR BOREHOLE PROTECTED WELL IN DWELLING.....31 PROTECTED WELL IN YARD/PLOT .32 PROTECTED PUBLIC WELL .....33 SURFACE WATER SPRING.....41 RIVER/STREAM.....42 POND/LAKE.....43 DAM.....44 RAINWATER .....51 TANKER TRUCK.....61 BOTTLED WATER .....71 OTHER _____ 96 (SPECIFY)	→ 23 → 23 → 23 → 23 → 23 → 23 → 23 → 23
22	How long does it take you to go there, get water, and come back?	MINUTES ..... ☐☐☐ ON PREMISES.....996	
23	What kind of toilet facilities does your household have?	FLUSH TOILET .....11 PIT TOILET/LATRINE TRADITIONAL PIT TOILET .....21 VENTILATED IMPROVED PIT (VIP) LATRINE .....22 NO FACILITY/BUSH/FIELD .....31 OTHER _____ 96 (SPECIFY)	→ 25
24	Do you share these facilities with other households?	YES .....1 NO 2	
25	Does your household have (a) functioning: Electricity? Radio? Television? Telephone? Refrigerator? Generator?	YES NO ELECTRICITY .....1 2 RADIO .....1 2 TELEVISION .....1 2 TELEPHONE.....1 2 REFRIGERATOR .....1 2 GENERATOR.....1 2	
26	What type of fuel does your household mainly use for cooking?	ELECTRICITY .....01 LPG/NATURAL GAS .....02 BIOGAS.....03 KEROSENE.....04 COAL, LIGNITE.....05 CHARCOAL.....06 FIREWOOD, STRAW.....07 DUNG .....08 OTHER _____ 96 (SPECIFY)	

27	MAIN MATERIAL OF THE FLOOR. RECORD OBSERVATION.	NATURAL FLOOR EARTH/SAND .....11 DUNG .....12 RUDIMENTARY FLOOR WOOD PLANKS.....21 PALM/BAMBOO .....22 FINISHED FLOOR PARQUET OR POLISHED WOOD.....31 VINYL OR ASPHALT STRIPS .....32 CERAMIC TILES.....33 CEMENT .....34 CARPET.....35 OTHER _____ 96 (SPECIFY)	
28	Does any member of your household own: A bicycle? A motorcycle or motor scooter? A car or truck? A tractor? An animal-drawn cart?	YES NO BICYCLE .....1 2 MOTORCYCLE/SCOOTER .....1 2 CAR/TRUCK.....1 2 TRACTOR .....1 2 ANIMAL DRAWN CART.....1 2	

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	How long have you been living continuously in (NAME OF CURRENT PLACE OF RESIDENCE)? IF LESS THAN ONE YEAR, RECORD '00' YEARS AND THEN THE NUMBER OF MONTHS.	YEARS..... ☐☐ MONTHS..... ☐☐ ALWAYS.....95	
102	How old were you at your last birthday? THIS QUESTION MUST NOT BE LEFT BLANK.	AGE IN COMPLETED YEARS ☐☐	
103	Have you ever attended school?	YES .....1 NO 2	→107
104	What is the highest level of school you attended: Primary, JSS, SSS, or higher?	PRIMARY .....1 JSS.....2 SSS .....3 POST-SECONDARY (DEGREE) .....4 POST-SECONDARY (NON-DEGREE).....5	
105	What is the highest (class/year) you completed at that level?	CLASS/YEAR ..... ☐☐	
106	CHECK 108: PRIMARY ☐ JSS AND HIGHER ☐		→108

107	Can you read a letter or newspaper easily, with difficulty or not at all?	EASILY ..... 1 WITH DIFFICULTY ..... 2 NOT AT ALL 3	
108	Do you listen to the radio almost every day, at least once a week, less than once a week or not at all?	ALMOST EVERY DAY ..... 1 AT LEAST ONCE A WEEK ..... 2 LESS THAN ONCE A WEEK ..... 3 NOT AT ALL 4	
109	What is your religion?	CATHOLIC ..... 1 PROTESTANT ..... 2 COCIN ..... 3 OTHER CHRISTIAN ..... 4 ISLAM ..... 5 TRADITIONAL RELIGION ..... 6 NO RELIGION 7	
110	What is your ethnic group?	YORUBA ..... 1 HAUSA ..... 2 IGBO ..... 3 LANGTANG ..... 4 BIROM ..... 5 OTHER _____ 6 (SPECIFY)	

SECTION 2: REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES ..... 1 NO 2	→206
202	Do you have any sons or daughters to whom you have given birth who are now living with you?	YES ..... 1 NO 2	→204
203	How many sons live with you? And how many daughters live with you? IF NONE, RECORD '00'.	SONS AT HOME ..... [ ][ ] DAUGHTERS AT HOME ..... [ ][ ]	
204	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you?	YES ..... 1 NO 2	→206
205	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? IF NONE, RECORD '00'.	SONS ELSEWHERE ..... [ ][ ] DAUGHTERS ELSEWHERE .. [ ][ ]	
206	Have you ever given birth to a boy or girl who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	YES ..... 1 NO 2	→208
207	How many boys have died? And how many girls have died? IF NONE, RECORD '00'.	BOYS DEAD ..... [ ][ ] GIRLS DEAD ..... [ ][ ]	

208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL ..... ☐☐	
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL _____ births during your life. Is that correct? YES CORRECT ☐ NO ☐ → PROBE AND 201-208 AS NECESSARY.		

SECTION 3. CONTRACEPTION

Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. CIRCLE CODE 1 IN 301 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 301, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 1 IF METHOD IS RECOGNIZED, AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 301, ASK 302.

301	Which ways or methods have you heard about? FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK: Have you ever heard of (METHOD)?		302 Have you ever used (METHOD)?
01	FEMALE STERILIZATION Women can have an operation to avoid having any more children.	YES .....1 NO .....2 ▼	Have you ever had an operation to avoid having any more children? YES .....1 NO 2
02	MALE STERILIZATION Men can have an operation to avoid having any more children.	YES .....1 NO .....2 ▼	Have you ever had a partner who had an operation to avoid having any more children? YES .....1 NO 2
03	PILL Women can take a pill every day to avoid becoming pregnant.	YES .....1 NO .....2 ▼	YES .....1 NO 2
04	IUD Women can have a loop or coil placed inside them by a doctor or a nurse.	YES .....1 NO .....2 ▼	YES .....1 NO 2
05	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months.	YES .....1 NO .....2 ▼	YES .....1 NO 2
06	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	YES .....1 NO .....2 ▼	YES .....1 NO 2
07	CONDOM Men can put a rubber sheath on their penis before sexual intercourse.	YES .....1 NO .....2 ▼	YES .....1 NO 2
08	FEMALE CONDOM Women can place a sheath in their vagina before sexual intercourse.	YES .....1 NO .....2 ▼	YES .....1 **NO 2**
09	LACTATIONAL AMENORRHEA METHOD (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned.	YES .....1 NO .....2 ▼	YES .....1 NO 2
10	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	YES .....1 NO .....2 ▼	YES .....1 NO 2
11	WITHDRAWAL Men can be careful and pull out before climax.	YES .....1 NO 2	YES .....1 NO 2

		▼	
12	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES ..... 1 _____ (SPECIFY) _____ (SPECIFY) NO 2	YES ..... 1 NO ..... 2 YES ..... 1 NO 2

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
303	Are you pregnant now?	YES ..... 1 NO ..... 2 UNSURE 3	→308
304	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES ..... 1 NO 2	→308
305 305A	Which method are you using? IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR MOST EFFICACIOUS METHOD ON LIST. CIRCLE '01' FOR FEMALE STERILIZATION.	FEMALE STERILIZATION ..... 01 MALE STERILIZATION ..... 02 PILL ..... 03 IUD ..... 04 INJECTABLES ..... 05 IMPLANTS ..... 06 CONDOM ..... 07 FEMALE CONDOM ..... 08 DIAPHRAGM ..... 09 FOAM/JELLY ..... 10 LACTATIONAL AMEN. METHOD ..... 11 PERIODIC ABSTINENCE ..... 12 WITHDRAWAL ..... 13 OTHER _____ 96 (SPECIFY)	→306 →310 →310 →310
306 306A	Where did you obtain (CURRENT METHOD) the last time? Where did your sterilization take place?	HOSPITAL ..... 11 HEALTH CENTER ..... 12 FAMILY PLANNING CLINIC ..... 13 FIELDWORKER ..... 15 COMMUNITY-BASED AGENT ..... 16 TBA ..... 17 PHARMACY ..... 22 PRIVATE DOCTOR ..... 23 SHOP ..... 31 FRIEND/RELATIVE ..... 33 OTHER _____ 96 (SPECIFY)	
307	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all?	THEN ..... 1 LATER ..... 2 NOT AT ALL 3	
308	Do you know of a place where you can obtain a method of family planning?	YES ..... 1 NO 2	→310

309	Where is that? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. (NAME OF PLACE) _____ Any other place? RECORD ALL PLACES MENTIONED	HOSPITAL	**YES** 1	NO 0
		HEALTH CENTER	1	0
		FAMILY PLANNING CLINIC	1	0
		FIELDWORKER	1	0
		COMMUNITY-BASED AGENT	1	0
		TBA	1	0
		PHARMACY	1	0
		PRIVATE DOCTOR	1	0
		SHOP	1	0
		FRIEND/RELATIVE	1	0
		OTHER _____(SPECIFY)	1	0

310	In the last 12 months, were you visited by an agent who talked to you about family planning?	YES.....1 NO.....2	→401
311	What organization was the person from?	COCIN/CEDPA.....1 PPFN.....2 OTHER.....3 DON'T KNOW.....8	
312	In the last 3 months, have you discussed the practice of family planning with your friends, neighbors, or relatives?	YES.....1 NO.....2	
313	CHECK 305/305A ANY CODE CIRCLED ☐▼ NO CODE CIRCLED ☐		→401
314	You have told me that you are currently using contraception. Would you say that using contraception is mainly your decision, mainly your husband's decision or did you both decide together?	MAINLY RESPONDENT.....1 MAINLY HUSBAND/PARTNER.....2 JOINT DECISION.....3 OTHER _____ 6 (SPECIFY)	
315	Now I want to ask you about your husband's/partner's views on family planning. Do you think that your husband/partner approves or disapproves of couples using a contraceptive method to avoid pregnancy?	APPROVES.....1 DISAPPROVES.....2 DON'T KNOW.....8	
316	How often have you talked to your husband/partner about family planning in the past year?	NEVER.....1 ONCE OR TWICE.....2 MORE OFTEN.....3	

SECTION 4. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	What is your marital status now: are you married, living in union, widowed, divorced, or separated?	MARRIED .....1 LIVING IN UNION .....2 WIDOWED .....3 DIVORCED .....4 SEPARATED 5	→404
402	Does your husband/partner have any other wives besides yourself?	YES .....1 NO 2	→404
403	How many other wives does he have?	NUMBER. ..... [ ][ ] DON'T KNOW 98	
404	How old were you when you started living with a man?	AGE ..... [ ][ ]	
405	When was the last time you had sexual intercourse? RECORD 'YEARS AGO' ONLY IF LAST INTERCOURSE WAS ONE OR MORE YEARS AGO. IF 12 MONTHS OR MORE, ANSWER MUST BE RECORDED IN YEARS.	DAYS AGO .....1 [ ][ ] WEEKS AGO .....2 [ ][ ] MONTHS AGO .....3 [ ][ ] YEARS AGO .....4 [ ][ ]	→407
406	The last time you had sexual intercourse, was a condom used?	YES .....1 NO 2	
407	In your marriage/relationship, who would you say has more influence over whether to have sex – you, your husband/partner, or both of you equally?	RESPONDENT .....1 PARTNER .....2 BOTH EQUALLY .....3 DON'T KNOW/UNSURE 8	
408	Some couples find it difficult to talk about sex while others do not. For you and your partner, is it very difficult to talk about sex, somewhat difficult, or not difficult to talk about sex?	VERY DIFFICULT .....1 SOMEWHAT DIFFICULT .....2 NOT DIFFICULT .....3 DON'T KNOW/UNSURE 8	
409	Husbands and wives do not always agree on everything. Please tell me if you think a wife is justified in refusing to have sex with her husband when: She knows her husband has a sexually transmitted disease? She knows her husband has sex with women (other than his wives)? She has recently given birth? She is tired or not in the mood?	YES NO DK HAS STD .....12 8 OTHER WOMEN .....12 8 RECENT BIRTH .....12 8 TIRED/MOOD 12 8	
410	Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	YES .....1 NO 2	→501
411	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES .....1 NO 2	→501
412	What can a person do?	ABSTAIN FROM SEX ..... Y=1, NO=0	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
	Anything else? RECORD ALL WAYS MENTIONED.	USE CONDOMS	1	0	
		LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER	1	0	
		LIMIT NUMBER OF SEXUAL PARTNERS	1	0	
		AVOID SEX WITH PROSTITUTES	1	0	
		AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS	1	0	
		AVOID SEX WITH HOMOSEXUALS	1	0	
		AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY	1	0	
		AVOID BLOOD TRANSFUSIONS	1	0	
		AVOID INJECTIONS	1	0	
		AVOID SHARING RAZORS/BLADES	1	0	
		AVOID KISSING	1	0	
		AVOID MOSQUITO BITES	1	0	
		SEEK PROTECTION FROM TRADITIONAL HEALER	1	0	
		OTHER _____ (SPECIFY)	1	0	
		OTHER _____ (SPECIFY)	1	0	
		DON'T KNOW	1	0	

SECTION 5. FERTILITY PREFERENCES

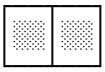
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	CHECK 305/305A: NEITHER STERILIZED ☐ ▼ HE OR SHE STERILIZED ☐		→601
502	CHECK 303: NOT PREGNANT OR UNSURE ☐ ▼ Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children? PREGNANT ☐ ▼ Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	HAVE (A/ANOTHER) CHILD 1 NO MORE/NONE 2 →504 SAYS SHE CAN'T GET PREGNANT 3 →510 UNDECIDED/DON'T KNOW: AND PREGNANT 4 →509 AND NOT PREGNANT OR UNSURE 5 →507	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
503	CHECK 303: NOT PREGNANT OR UNSURE → How long would you like to wait from now before the birth of (a/another) child? PREGNANT → After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?	MONTHS .....1 ☐☐ YEARS .....2 ☐☐ SOON/NOW ..... 993 →508 SAYS SHE CAN'T GET PREGNANT.... 994 →510 AFTER MARRIAGE..... 995 OTHER _____ 996 →508 (SPECIFY) DON'T KNOW 998	
504	CHECK 303: NOT PREGNANT OR UNSURE PREGNANT		→509
505	CHECK 304: USING A CONTRACEPTIVE METHOD? NOT CURRENTLY USING CURRENTLY USING		→507
506	CHECK 503: NOT ASKED 24 OR MORE MONTHS OR 02 OR MORE YEARS 00-23 MONTHS OR 00-01 YEAR		→509
507	In the next few weeks, if you discovered that you were pregnant, would that be a big problem, a small problem, or no problem for you?	BIG PROBLEM.....1 SMALL PROBLEM .....2 NO PROBLEM.....3 SAYS SHE CAN'T GET PREGNANT/NOT HAVING SEX 4	
508	CHECK 304: USING A CONTRACEPTIVE METHOD? NO, NOT CURRENTLY USING YES, CURRENTLY USING		→510
509	Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?	YES .....1 NO .....2 DON'T KNOW 8	
510	CHECK 203 & 205: HAS LIVING CHILDREN → If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be? NO LIVING CHILDREN → If you could choose exactly the number of children to have in your whole life, how many would that be? PROBE FOR A NUMERIC RESPONSE.	NUMBER ..... ☐☐ OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
511	CHECK 311/311A: NEITHER STERILIZED ☐ ▼ HE OR SHE STERILIZED ☐		→601
512	Do you think your husband/partner wants the same number of children that you want, or does he want more or fewer than you want?	SAME NUMBER ..... 1 MORE CHILDREN ..... 2 FEWER CHILDREN ..... 3 DON'T KNOW 8	

SECTION 6. HUSBAND'S BACKGROUND AND WOMAN'S WORK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	CHECK 401 AND 402: CURRENTLY MARRIED/ LIVING WITH A MAN ☐ FORMERLY MARRIED/ LIVED WITH A MAN ☐		→603
602	How old was your husband/partner on his last birthday?	AGE IN COMPLETED YEARS ☐☐	
603	Did your (last) husband/partner ever attend school?	YES ..... 1 NO 2	→606
604	What was the highest level of school he attended: Primary, JSS, SSS or post-secondary?	PRIMARY ..... 1 JSS ..... 2 SSS ..... 3 POST-SECONDARY (DEGREE) ..... 4 POST-SECONDARY (NON-DEGREE) ..... 5 DON'T KNOW 8	→606 →606
605	What was the highest (class/year) he completed at that level?	CLASS/YEAR ..... ☐☐ DON'T KNOW 98	
606	CHECK 701: CURRENTLY MARRIED/ LIVING WITH A MAN ☐ ▼ What is your husband's/partner's occupation? That is, what kind of work does he mainly do? FORMERLY MARRIED/ LIVED WITH A MAN ☐ ▼ What was your (last) husband's/ partner's occupation? That is, what kind of work did he mainly do?	☐☐ _____ _____ _____	
607	Aside from your own housework, are you currently working?	YES ..... 1 NO 2	→610
608	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. Are you currently doing any of these things or any other work?	YES ..... 1 NO 2	→610
609	Have you done any work in the last 12 months?	YES ..... 1 NO 2	→701

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
610	What is your occupation, that is, what kind of work do you mainly do?	_____  _____	
611	CHECK 610: WORKS IN AGRICULTURE ▼ DOES NOT WORK IN AGRICULTURE	→613	
612	Do you work mainly on your own land or on family land, or do you work on land that you rent from someone else, or do you work on someone else's land?	OWN LAND ....1 FAMILY LAND ....2 RENTED LAND ....3 SOMEONE ELSE'S LAND 4	
613	Do you do this work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER ....1 FOR SOMEONE ELSE ....2 SELF-EMPLOYED 3	
614	Do you usually work at home or away from home?	HOME ....1 AWAY 2	
615	Do you usually work throughout the year, or do you work seasonally, or only once in a while?	THROUGHOUT THE YEAR ....1 SEASONALLY/PART OF THE YEAR ....2 ONCE IN A WHILE 3	
616	Are you paid or do you earn in cash or kind for this work or are you not paid at all?	CASH ONLY ....1 CASH AND KIND ....2 IN KIND ONLY ....3 NOT PAID 4	→701
617	Who mainly decides how the money you earn will be used?	RESPONDENT ....1 HUSBAND/PARTNER ....2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ....3 SOMEONE ELSE ....4 RESPONDENT AND SOMEONE ELSE JOINTLY 5	
618	On average, how much of your household's expenditures do your earnings pay for: almost none, less than half, about half, more than half, or all?	ALMOST NONE ....1 LESS THAN HALF ....2 ABOUT HALF ....3 MORE THAN HALF ....4 ALL ....5 NONE, HER INCOME IS ALL SAVED. 6	

SECTION 7. HOUSEHOLD DECISION MAKING AND POLITICAL PARTICIPATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	Now I would like to ask you some questions about financial matters. I ask these questions only to understand more about the financial position of women. Please tell me if you alone, or jointly with your husband or someone else own....	DOES NOT OWN ALONE / OWNS JOINTLY / OWNS — 702: If you ever need to, can you sell (ASSET) without anyone else's permission? YES / NO	
	Land?	1 / 2 / 3→ — 1 / 2	
	The house/dwelling you live in?	1 / 2 / 3→ — 1 / 2	
	Any other house, apartment, or dwelling?	1 / 2 / 3→ — 1 / 2	
	Livestock such as (Chicken, goats, pigs or sheep)?	1 / 2 / 3→ — 1 / 2	
	Farm produce (such as potatoes, corn, millet, vegetables, etc)?	1 / 2 / 3→ — 1 / 2	
703	Who in your family usually has the final say on the following decisions:	RESPONDENT = 1 HUSBAND/PARTNER = 2 RESPONDENT & HUSBAND/PARTNER JOINTLY = 3 SOMEONE ELSE = 4 RESPONDENT & SOMEONE ELSE JOINTLY = 5 DECISION NOT MADE/NOT APPLICABLE = 6	
	Your own health care?	1 2 3 4 5 6	
	Making large household purchases?	1 2 3 4 5 6	
	Making household purchases for daily needs?	1 2 3 4 5 6	
	Visits to family or relatives?	1 2 3 4 5 6	
	What food should be cooked each day?	1 2 3 4 5 6	
	Whether or not you should work to earn money?	1 2 3 4 5 6	
704	PRESENCE OF OTHERS AT THIS POINT (PRESENT AND LISTENING, PRESENT BUT NOT LISTENING OR NOT PRESENT)	PRES/ LISTEN. / PRES/ NOT LISTEN. / NOT PRES	
		CHILDREN >10 ..... 1 — 2 — 8	
		HUSBAND ..... 1 — 2 — 8	
		OTHER MALES ..... 1 — 2 — 8	
		OTHER FEMALES..... 1 — 2 — 8	
705	Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations:	YES / NO / DK	
	If she goes out without telling him?	GOES OUT ..... 1 — 2 — 8	
	If she neglects the children?	NEGL. CHILDREN ... 1 — 2 — 8	
	If she argues with him?	ARGUES ..... 1 — 2 — 8	
	If she refuses to have sex with him?	REFUSES SEX ..... 1 — 2 — 8	
	If she burns the food?	BURNS FOOD ..... 1 — 2 — 8	
	If she uses contraceptives without his knowledge?	CONTRACEPTIVES 1 — 2 — 8	
706	Are you usually permitted to go to the following places on your own, only if someone accompanies you, or not at all?	ALONE / NOT ALONE / NEVER	
	To the local market to buy things?	MARKET..... 1 — 2 — 8	
	To a local health center or doctor?	HEALTH CENTER.... 1 — 2 — 8	
	To the community center or other nearby meeting place?	COMM CENTER ..... 1 — 2 — 8	
	To homes of friends in the neighborhood?	FRIEND HOME ..... 1 — 2 — 8	
	To a nearby mosque/temple/church?	CHURCH ..... 1 — 2 — 8	
	Just outside your house or compound?	OUTSIDE..... 1 — 2 — 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
707	Now I would like to ask you some questions about medical care for yourself. Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not? Knowing where to go. Getting permission to go. Getting money needed for treatment. The distance to a health facility. Having to take transport. Not wanting to go alone. Concern that there may not be a female health provider.	BIG PROBLEM / NOT A PROBLEM WHERE TO GO ..... 1 2 PERMISSION..... 1 2 MONEY ..... 1 2 DISTANCE ..... 1 2 TRANSPORT ..... 1 2 GO ALONE ..... 1 2 FEM. PROVIDER..... 1 2	
708	Please tell me if you agree or disagree with the following statements: Women in Nigeria can be political leaders. Women in Nigeria should participate in politics. I would support a woman to represent my community as LGA chairperson. I would vote for a woman in an election.	AGREE / DIS-AGREE / DK LEADERS..... 1 2 8 PARTICIPATE..... 1 2 8 REPRESENT ..... 1 2 8 VOTE..... 1 2 8	
709	Do you think that a woman should be entitled to inherit her late husband's property/possessions?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
710	Do you think a woman should be entitled to own farmland?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
711	Are you a member of any women's groups, clubs, or organizations?	YES ..... 1 NO 2	→714

712	To which groups, clubs, or organizations do you belong? PROBE: Any others? CIRCLE ALL MENTIONED.		YES	NO
		CO-OPERATIVE SOCIETY.....	1	2
		PROFESSIONAL GROUP.....	1	2
		CULTURAL GROUP.....	1	2
		RELIGIOUS GROUP	1	2
		POLITICAL GROUP	1	2
		PEACE GROUP	1	2
		OTHER (SPECIFY)	1	2
713	Are you registered to vote?	YES..... 1 NO..... 2		
714	Are you a member of a political party?	YES..... 1 NO..... 2		

715	Do you know the name of the LGA chairperson for this community? (Elected or Caretaker/Transition chairperson)	YES.....1 NO.....2	→717
716	What is his/her name?	CORRECT.....1 NOT CORRECT.....2	
717	Do you know the name of the governor of your state?	YES.....1 NO.....2	→719
718	What is his/her name? (JOSHUA DARIYE)	CORRECT.....1 NOT CORRECT.....2	
719	Have you ever met with or contacted the LGA chairperson or any other local official?	YES.....1 NO.....2	
720	Have you ever participated in any political protests or demonstrations or political campaigns?	YES.....1 NO.....2	
721	Have you ever attended a political meeting?	YES.....1 NO.....2	
722	In the last 3 years, have you participated in any activity or event conducted by COCIN?	YES.....1 NO.....2	→724
723	Now I would like to ask you some questions about activities in which you have participated over the past three years. Please tell me if you have participated in the following: Voter registration? Civic/voter education? Social mobilization? Vanguard of democracy? Advocacy? Conflict management? 100 "women group"? Transparency and accountability (fila fila)? Sensitisation and awareness creation? OTHERS (SPECIFY) _____	YES NO DK VOTER REG.....1 2 8 VOTER ED.....1 2 8 SOC MOB.....1 2 8 VANG DEM.....1 2 8 ADVOCACY.....1 2 8 CONFLICT MGMT... 1 2 8 100 WOMEN.....1 2 8 FILA FILA.....1 2 8 SENSITISATION..... 1 2 8	
724	RECORD THE TIME.	HOUR ..... ☐☐ MINUTES..... ☐☐	

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR:_____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR:_____ DATE: _____

FORM FOR HOUSEHOLD LISTING EXERCISE

H1	EA NUMBER	
H2	COCIN LCC NAME	
H3	VILLAGE	
H4	STREET	
H5	Household Address	
H6	Sex of the head of household	Male……1 Female…….2
H7	Total number of people in the household	/__/__/
H8	Total number of females in the household	/__/__/
H9	Total number of males in the household **CHECK H8 and H9 MUST SUM UP TO H7**	/__/__/
H10	Total Number of females below 15 years	/__/__/
H11	Total number of females above 49 years	/__/__/

Table B: listing of Female members of the Household 15-49years

	Now I want to ask you about females in this household who are between 15 and 49 years. List them with Identification number	
Identification number	Age	Marital Status
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Marital Status: Ever married 1
Ever lived in union 2
Never married/lived in union 3

PLEASE ENSURE THAT WHEN H10, H11 and the LAST ROW filled in TABLE B SUMS TO H8.

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⊖ denotes countries with ENABLE projects

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THE CENTRE FOR DEVELOPMENT
AND POPULATION ACTIVITIES

Headquartered in Washington, DC, CEDPA is an international nonprofit organization that seeks to empower women at all levels of society to be full partners in development. Founded in 1975, CEDPA supports programs and training in leadership, capacity building, advocacy, governance and civil society, youth participation and reproductive health.

The Enabling Change for Women's Reproductive Health (ENABLE) project works to strengthen women's capabilities for informed and autonomous decision making to prevent unintended pregnancy and improve reproductive health. Initiated in 1998, ENABLE seeks to increase the capacity of non-governmental organization (NGO) networks to expand reproductive health services and to promote a supportive environment for women's decision making.

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